

MEDICAL ASSISTANCE
State: North Carolina

**PROSPECTIVE REIMBURSEMENT PLAN FOR ICF-MR FACILITIES
PAYMENT FOR SERVICES**

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.0301 Payment for Services-Prospective Reimbursement Plan for ICF-MR Facilities

All certified intermediate care facilities - mentally retarded (ICF-MR) participating in the North Carolina Medicaid Program are reimbursed on a prospective basis as set forth hereunder, except that state-operated facilities shall be reimbursed their reasonable and allowable costs in accordance with the Medicare principles of reimbursement and with the applicable provisions of this plan. This plan is developed in accordance with the requirements of 42 CFR 447 Subpart C - Payment for Inpatient Hospital and Long-Term Care Facility Services. Providers shall comply with all federal regulations and with the provisions of this plan.

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REPORTING REQUIREMENTS

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.0302 REPORTING REQUIREMENTS

- (a) Financial reports shall include the following:
 - (1) Budget reports: Each provider shall include appropriate budget information in its application for an initial rate for a new facility:
 - (A) The budget shall reflect the projected annual operating results of each of two years subsequent to the commencement of operating said facility.
 - (B) The budget information used to support the Certificate of Need award shall be provided to the Division of Medical Assistance on or before 30 days prior to the enrollments of said facility by the Medicaid program.
 - (C) Budgets are not deemed to be appropriately filed unless they are properly prepared, in accordance with rules established by the Division of Medical Assistance.
 - (2) Cost reports: Each facility that receives payments from the North Carolina Medicaid Program shall prepare and submit a separate annual cost report of its costs, a working trail balance related to reimbursement, and other financial information as requested by the Division of Medical Assistance. Providers that have an approved combined uniform rate in accordance with Section .0304 Paragraph (n) of this reimbursement plan shall file a combined cost report that is supported by the individual facility cost reports. For these providers, the combined cost report shall be filed with the Division of Medical Assistance Audit Section while the individual facility cost reports shall be filed with the Division of Medical Assistance Rate Setting Section.
 - (A) The cost report shall cover a 12 month period, from July 1 to the following June 30, unless another time frame is specified by the Division of Medical Assistance.
 - (i) A short year cost report shall be filed for facilities certified in the Medicaid program during the year, with the cost report period commencing on the date of certification and ending the following June 30.
 - (ii) A short year cost report shall be filed for facilities terminated from the Medicaid program during the year, with the cost report period commencing on July 1 and ending on the date of termination.
 - (B) The cost report shall be submitted to the state on or before the September 30 that immediately follows the June 30 year end. The Division of Medical Assistance may grant an extension of time of up to 30 days for filing the cost report, upon showing of just cause in writing by the provider. For purposes of this Section, "just cause" is an action that is uncontrollable by the provider, such as tornado, hurricane, strong wind damage, etc.
 - (C) For new facilities a cost report shall be submitted for the period beginning with the date of certification and ending on the following June 30.
 - (D) The cost report shall be based on the Chart of Accounts specified by the Division of Medical Assistance. The Chart of Accounts includes a description of each account to be used on the cost report. The Chart of Accounts shall be distributed

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to each provider by the Division of Medical Assistance. This material is available for inspection and copies may be obtained from the Division at 1985 Umstead Drive, Raleigh, North Carolina 27603 at a cost of twenty cents (\$.20) per page. All costs shall be shown on the cost reports in accordance with rules established by the Division of Medical Assistance. A cost report that does not meet the requirements of the Division of Medical Assistance is deemed not to be filed.

- (E) Currently filed cost reports shall reflect the decisions and judgments expressed by the Division of Medical Assistance auditors on previous cost reports.
- (F) All related organizations shall file a Medicaid cost statement identifying their costs, adjustments to costs, and allocations of costs along with the ICF-MR facility's cost report. A home office, or parent company, shall be recognized as a related organization. Auditable records to support these costs shall be made available to the Division of Medical Assistance and its designated contract auditors. Undocumented costs shall be disallowed for Medicaid reimbursement.
- (G) Cost reports shall clearly identify related party transactions. Failure to do so may result in the related cost being disallowed for Medicaid reimbursement purposes.
- (H) A combined cost report may only be filed for facilities that use the same cost settlement methodology and have a uniform rate, as approved by the Division of Medical Assistance.

(b) Additional information reporting requirements for facilities shall include , but not be limited to, the following:

- (1) Each facility providing day treatment services shall be required to submit, in conjunction with the cost report, a separate report itemizing the actual expense attributable to the provision of day treatment services and the actual number of client days associated with said expense.
- (2) Each provider operating a facility, upon the request of the Division of Medical Assistance, shall submit statistical data and other information relevant to the administration and operation of said facility. Such reports shall be submitted within the time frames authorized in the request.
- (3) Each provider that issues an annual report to its shareholders shall file a copy of said report with the Division of Medical Assistance. Said report shall be filed within 30 days of its issuance to the shareholders.
- (4) Each provider that has a compensatory stock option plan shall file a copy of said plan with the Division of Medical Assistance, within 30 days of its implementation.
- (5) A provider shall file an information report with the Division of Medical Assistance within 30 days of receiving notification from either the North Carolina Department of Revenue or the Internal Revenue Service that items, previously reported and allowed on a cost report, have been disallowed on the provider's associated tax return.

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- (c) Requirements for certification of financial reports.
- (1) Each provider that operates a facility shall complete the required financial reports in accordance with the following rules and in the order of priority stated:
 - (A) Cost shall be represented in accordance with the specific provisions as set forth in this Plan.
 - (B) Costs shall be reported in conformance with the Medicare Provider Reimbursement Manual, HCFA-15, which is hereby incorporated by reference including subsequent amendments and editions. Said manual is commonly referred to as the HCFA-15 manual and is available for inspection at the Division of Medical Assistance, 1985 Umstead Drive, Raleigh, NC 27603. Copies may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325 at a cost of three hundred fifty seven dollars (\$357.00). Tel: (202) 783-3238.
 - (C) Costs shall be reported in conformance with generally accepted accounting principles.
 - (D) Governmental institutions have the option of using the accrual or cash method of accounting.
 - (2) Cost reports prepared for facilities shall be certified for their compliance with Subparagraph (c)(1) of this Section by the provider's executive director or designated officer.
 - (3) Budget reports prepared for facilities shall be certified for their fair representation of anticipated disbursements and receipts related to the Medicaid ICF-MR program by the provider's executive director or designated officer.
- (d) Requirements for the revision of financial reports shall include the following:
- (1) In the event the Division of Medical Assistance determines a cost report does not meet the requirement of the Division of Medical Assistance during a detailed review, the provider shall have 30 days from the date of said notification to submit a revised cost report or additional data. Such revised data or report shall be certified by the provider's executive director or designated officer.
 - (2) In the event that the provider discovers that a report submitted to the Division of Medical Assistance **is incomplete, inaccurate, or incorrect, the provider shall immediately notify the Division of Medical Assistance** that such error(s) exist. The provider shall have 30 days from the date of said notification to submit a revised report or additional data. Such data or report shall meet the certification requirements of the report being corrected.
 - (3) Failure to file the corrected reports on a timely basis in accordance to either Subparagraph (d)(1) or (2) of this Section shall result in the related report being considered not filed and subject to the provisions under this State Plan related to the failure to file said reports. **However, the Division of Medical Assistance may grant an extension of time of up to 30 days to file said corrected reports, upon the showing of just cause by the provider in writing.**

REQUIREMENTS FOR FINANCIAL RECORDS

.0303 REQUIREMENTS FOR FINANCIAL RECORDS

Each provider shall maintain facility-specific financial records which reflect all expenditures incurred and revenues earned related to its ICF-MR services in the Medicaid Program. In addition, the financial records shall properly and clearly reflect all other sources of funds available to the facility's Medicaid ICF-MR program.

- (1) Such financial records shall provide clear and precise justification and support for entries included in the cost report, and included in related budgets.
- (2) The financial records shall include at a minimum separate accounts for each type of expense, revenue, and other funding resources included in the annual cost report.
 - (A) All items on the cost report shall be supported by clear and precise financial records. Cost reports that fail this requirement are deemed to be improperly filed and subject to the provisions under this **plan** related to the failure to file said reports.
- (3) Effective July 1, 1993, property ownership and use, housekeeping, and operation and maintenance of plant costs related to day treatment services should be separately accounted for on the provider's books and records. Said costs should be reported separately as direct care costs on the 1994 cost report, consistent with guidelines established by the Division of Medical Assistance.

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RATE SETTING METHODS FOR NON-STATE FACILITIES

.0304 RATE SETTING METHOD FOR NON-STATE FACILITIES

(a) A prospective rate shall be determined annually for each non-state facility to be effective for dates of service for a 12 month rate period beginning each July 1. The prospective rate shall be paid to the provider for every Medicaid eligible day during the applicable rate year. The prospective rate may be determined after the effective date and paid retroactively to that date. **The prospective rate is based on the 1993 base year. This plan does not authorize rebasing.** The prospective rate may be changed due to a rate appeal under Section .0308 of this State Plan or facility reclassification under Paragraph (b) of this Section. Each non-state facility, except those facilities where Paragraph (v) below applies, shall be classified into one of the following groups:

- (1) Group 1- Facilities with 32 beds or less.
- (2) Group 2- Facilities with more than 32 beds.
- (3) Group 3- Facilities with medically fragile clients. For rate reimbursement purposes under this Section medically fragile clients are defined as any individual with complex medical problems who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hour a day medical/nursing/health supervision or intervention.
- (4) **Facilities in group 1 or 2 in Subparagraph (a)(1) or (2) of this Section shall be further classified in accordance to the level of disability of the facility's clients, as measured by the Developmental Disabilities Profile (DDP) assessment instrument. A summary of the levels of disability is shown in the following chart:**

FACILITY DDP SCORE

Level	Low	High
1	200.00	300.00
2	125.00	199.99
3	100.00	124.99
4	75.00	99.99
5	50.00	74.99

- (b) Facilities shall be reclassified into appropriate groups as defined in Paragraph (a) of this Section.
- (1) When a facility is reclassified, the rate shall be adjusted retroactively back to the date of the event that caused the reclassification. This adjustment shall give full consideration to any reclassification based on the change in facts or circumstances during the year. Overpayments related to this retroactive rate adjustments shall be repaid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.

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- (2) The provider shall be given the opportunity to appeal the merits of the reclassification of any facility, prior to any decision by the Division of Medical Assistance.
 - (3) The provider shall be notified in writing 30 days before the implementation of new rates resulting from the reclassification of any facility.
 - (4) The providers and the Division of Medical Assistance shall make every reasonable effort to ensure that each facility is properly classified for rate setting purposes.
 - (5) A provider shall file any request for facility reclassification in writing with the Division of Medical Assistance no later than 60 days subsequent to the proposed reclassification effective date.
 - (6) For facilities certified prior to July 1, 1993, the facility DDP score calculated for fiscal year 1993 shall be used to establish proper classification at July 1, 1995.
 - (7) For facilities certified after June 30, 1993, the most recent facility DDP score shall be used to establish proper classification.
 - (8) A facility reclassification review shall use the most current facility DDP score.
 - (9) A facility's DDP score shall be subject to independent validation by the Division of Medical Assistance.
 - (10) A new facility that has not had a DDP survey conducted on its clients shall be categorized as a level 2 facility for rate setting purpose, pending completion of the DDP survey. Upon completion of the DDP survey, the facility shall be subject to reclassification and rates shall be adjusted retroactively back to the date of certification. Overpayments related to this retroactive adjustment shall be paid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.
- (c) Facility rates under this Section shall be established at July 1, 1995, under the following:
- (1) For facilities certified prior to July 1, 1993, rates shall be derived from the 1993 cost reports.
 - (2) For facilities certified during fiscal year 1993-1994, the fiscal year 1994 facility specific cost report shall be used to derive rates.
 - (3) For facilities certified during fiscal year 1994-1995, the fiscal year 1995 facility specific cost report shall be used to derive rates.
 - (A) Rates for these facilities shall not be adjusted, except for the impact of inflation under Paragraph (k) of this Section, until the fiscal year 1995 cost report has been properly reviewed. Rates for these facilities shall be adjusted retroactively back to July 1, 1995, once the fiscal year 1995 facility specific cost report has been properly reviewed. Overpayments related to this retroactive rate adjustment shall be repaid to the Medicaid program. Underpayments related to this retroactive rate adjustment shall be paid to the provider.

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- (4) Facilities with rates established during a rate appeal proceeding with the Division of Medical Assistance during fiscal years 1994 or 1995 shall not have their rates established in accordance with Subparagraph (c)(1), (c)(2), or (c)(3) of this Section.
- (A) The rates for these facilities shall remain at the level approved in the rate appeal proceeding adjusted only for inflation, as reflected in Paragraph (k) of this Section.
- (d) For facilities certified after June 30, 1993, rates developed from filed cost reports for fiscal years subsequent to 1993 may be retroactively adjusted if there is found to exist more than a two percent difference between the filed per diem cost and either the desk audited or field audited per diem cost for the same reporting period. Rates developed from desk audited cost reports may be retroactively adjusted if there is found to exist more than a two percent difference between the desk audited per diem cost and the field audited per diem cost for the same reporting period. The rate adjustment may be made after written notification to the provider 30 days prior to implementation of the rate adjustment.
- (e) Each prospective rate developed in accordance with Subparagraph (c)(1), (c)(2), or (c)(3) of this Section consists of the sum of two components as follows:
- (1) Indirect care rate
- (2) Direct care rate.
- (f) A uniform industry wide indirect care rate shall be established for each facility category shown under Subparagraph (a)(1), (a)(2), or (a)(3) of this Section.
- (1) The indirect rate for group 1 facilities is **established at the fiftieth percentile of the following costs incurred by all facilities with six beds or less in the group 1 category, except those related by common ownership or control to more than 40 said facilities:**
- (A) The sum of the cost of property ownership and use (POU), administrative and general (A + G), and operation and maintenance of plant (OMP) as determined by the 1993 base year cost reports.
- (2) The indirect rate for group 2 facilities is **established at the fiftieth percentile of the costs noted in Part (f)(1)(A) of this Section incurred by the group 2 facilities, as determined by the 1993 base year cost reports.**
- (3) The indirect rate for group 3 facilities is **established at the fiftieth percentile of the costs noted in Part (f)(1)(A) of this Section incurred by the group 3 facilities, as determined by the 1993 base year cost reports.**
- (4) **The Group 1 facilities related by common ownership or control to more than 40 said facilities shall receive the same indirect rate as other Group 1 facilities.**
- (5) The indirect rates established under Subparagraphs (f)(1), (f)(2), and (f)(3) of this Section shall be reduced as determined based on industry cost analysis by an amount not to exceed four percent to account for expected operating efficiencies.
- (6) **The category specific indirect rate is established by determining the sum of the POU,**

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A + G, and OMP costs for each facility, dividing this sum by facility bed days to establish a per day indirect cost for all facilities in this category, arranging the per day indirect cost of all facilities in the category in ascending order, and setting the indirect rate for all related facilities at the indirect per diem cost falling at the fiftieth percentile.

(A) Each facility's percentile is calculated by dividing cumulative bed days, of the current facility and all facilities preceding the current facility in the ranking of all facilities, by total bed days of the industry. Therefore, the per diem cost at the fiftieth percentile represents that the cost of service of fifty percent of the bed days is rendered at or below this cost level.

(g) The facility's direct care rate shall be the lower of actual direct care per diem cost (actual cost divided by total bed days) or the per diem limit, as calculated in paragraph (g)(7).

(1) Direct care costs for facilities certified prior to July 1, 1993, shall be based on direct care costs reflected in the 1993 cost reports.

(2) The direct care costs for all facilities certified on or after July 1, 1993, are based on the first facility specific cost report filed after certification.

(3) Based on said cost report, the direct care cost is equal to the sum of all allowable costs reflected in the ICF-MR cost report cost centers, as included in the ICF-MR format effective July 1, 1993, except for the following indirect cost centers:

(A) Property ownership and use

(B) Operational and maintenance of plant and housekeeping -non-labor

(C) Administrative and general

(4) The fiftieth percentile cost limit shall be reduced by one percent each year, for the four year period beginning July 1, 1996, in order to account for expected operating efficiencies, as determined based on industry cost analysis.

(5) The fiftieth percentile cost limit shall be increased each year by price level changes calculated in accordance with Paragraph (k) of this Section.

(6) A direct care limit is established for each facility classification as established under Paragraph (a) of this section. A facility's classification is based on its size or medically fragile clients, per Subparagraphs (a)(1), (a)(2), and (a)(3), and based on the level of disability of the facility's clients, per Subparagraph (a)(4).

(7) The facility-specific classification, as determined under Paragraph (a) of this section, direct care cost limit is established by determining the sum of the direct costs for each facility, dividing the sum by facility bed days to establish a per day direct care cost of all facilities in the classification, arranging the per day direct care cost of all facilities in the classification in ascending order, and setting the direct care cost limit for all related facilities at the direct care per diem cost falling at the fiftieth percentile.

(A) Each facility's percentile is calculated by dividing cumulative bed days, of the current facility and all facilities preceding the current facility in the ranking of

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all facilities, by total bed days for the industry. Therefore, the per diem cost at the fiftieth percentile represents that the cost of service of fifty percent of the bed days is rendered at or below this cost level.

- (h) The indirect rate shall not be subject to cost settlement.
 - (1) Costs above the indirect rates shall not be paid to the provider.
 - (2) Costs savings below the indirect rate shall not be recouped from the provider.
- (i) The direct care rate shall be subject to cost settlement, based on the cost report, subject to audit, filed with the Division of Medical Assistance.
 - (1) Cost above the direct rate shall not be paid to the provider.
 - (2) Cost savings below the direct rate shall be recouped from the provider.
- (j) Facilities with rates established during a rate appeal proceeding with the Division of Medical Assistance during fiscal years 1994 or 1995 may choose to cost settle under the provisions of Paragraphs (h) and (i) of this Section, or under the following procedure:
 - (1) If, during a cost reporting period, total allowable costs are less than total prospective payments, then a provider may retain one-half of said difference, up to an amount of five dollars (\$5.00) per patient day. The balance of unexpended payments shall be refunded to the Division of Medical Assistance. Costs in excess of a facility's total prospective payment rate are not reimbursable.
 - (2) The facilities subject to the Paragraph shall make the election on cost settlement methodology on or before the filing of the annual cost report with the Division of Medical Assistance.
 - (3) An election to follow the cost settlement procedures of Paragraphs (h) and (i) of this Section shall be irrevocable.
 - (4) Rates established for these facilities during future rate appeal proceedings shall be subject to the cost settlement procedures of Paragraphs (h) and (i) of this Section.
- (k) To compute each facility's current prospective rate, the direct and indirect rates established by Paragraphs (f) and (g) of this Section shall be adjusted for price level changes since the base year. No inflation factor for any provider shall exceed the maximum amount permitted for that provider by federal or state law and regulations.
 - (1) Price level adjustment factors are computed using aggregate costs in the following manners:
 - (A) Costs shall be separated into three groups:
 - (i) Labor,
 - (ii) Non-Labor,
 - (iii) Fixed.
 - (B) The relative weight of each cost group is calculated to the second decimal point by dividing the total costs of each group (labor, nonlabor, and fixed) by the total cost of the three categories.
 - (C) Price level adjustment factors for each cost group shall be established as follows: